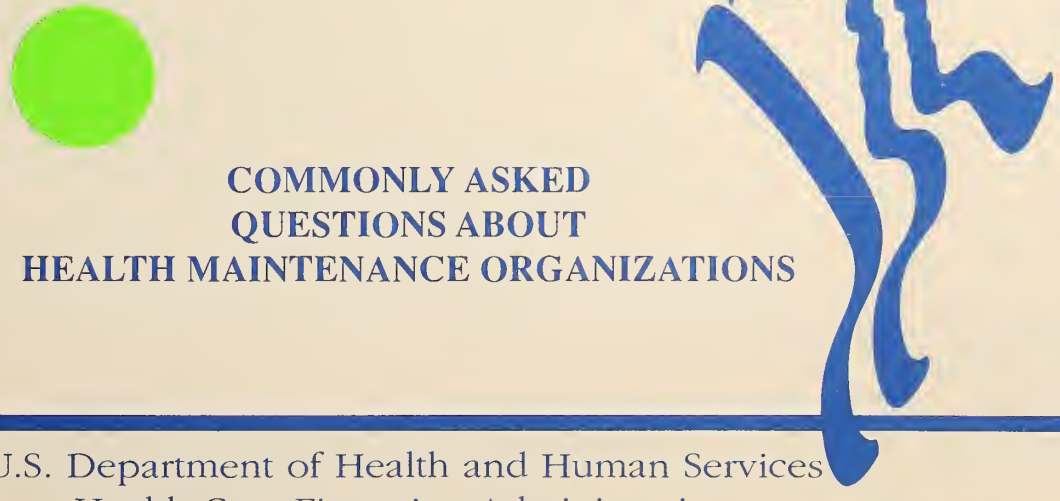
Medicare

Coordinated Care

Q&A



COMMONLY ASKED QUESTIONS ABOUT HEALTH MAINTENANCE ORGANIZATIONS

U.S. Department of Health and Human Services
Health Care Financing Administration

#7

COMMONLY ASKED QUESTIONS ABOUT HEALTH MAINTENANCE ORGANIZATIONS

ENROLLMENT 1

Q *Who can enroll in a Health Maintenance Organization (HMO) with a Medicare contract?*

A You can join an HMO with a Medicare contract and receive all Medicare covered benefits if you are enrolled in Part B of Medicare, live in the HMO's service area and the HMO is accepting new members.

ESRD

You may not enroll in an HMO if you have end-stage renal disease (ESRD). However, if you are already a commercial member of an HMO that has a Medicare contract, you may change to Medicare membership with the same HMO even if you have ESRD. You can make this change to Medicare membership as soon as you are eligible for Medicare (for example, you can make the change during the month you turn 65 years of age).

HOSPICE

You may not enroll in an HMO for Medicare services if you have elected hospice benefits. Other than these two reasons, an HMO may not refuse your request for enrollment because you are already sick or have some other kind of medical condition.

NO PART A 2

Q *What are the Health Maintenance Organization (HMO) enrollment rules for Medicare beneficiaries who are not entitled to Part A of Medicare?*

A If you are not entitled to Part A, you may still enroll in an HMO that has a contract to provide Medicare covered services. However, the HMO has the right to ask you to pay a premium for Part A services if you want to enroll as a Medicare member.

MEDICAID 3

Q *Can a Medicaid recipient who is also eligible for Medicare join a Health Maintenance Organization (HMO) which contracts with Medicare?*

A Yes. If you are eligible for Medicare and currently receiving Medicaid benefits, the State Medicaid program may pay the Medicare Part B premium and, where necessary, the Medicare Part A premium, so that you can receive medical services under Medicare. For more information contact your local Medicaid eligibility office. In some states Medicaid recipients are enrolled in Medicaid HMOs, so you would not want to enroll in two HMOs.

STILL WORKING

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Q *If I am working and covered by an employer group health plan, can I join a Medicare Health Maintenance Organization (HMO)?*

A Yes. If you are still working and eligible for Medicare, you may join a Medicare HMO if you have not turned down medical coverage under Part B of the Medicare program. The choice is yours. You can belong to your employer's group health plan and the Medicare HMO or you can choose between the two. Of course, you will want to carefully review the health care benefits offered by your employer's group health plan and compare those benefits to benefits provided by the Medicare HMO before you make your choice. If you choose to keep both health care plans, your employer group health plan will be the primary payer for your health care services and bills must be sent to your employer's group health plan first.

EFFECTIVE DATE

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Q *When is enrollment in a Medicare Health Maintenance Organization (HMO) effective?*

A An enrollment may be effective either the first day of the month after the application for enrollment is received by the HMO or up to three months later. All HMOs with Medicare contracts will give you written information when you join the HMO and will tell you when your enrollment is effective.

LOCK-IN

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Q *In a recent presentation, I heard a person from a Health Maintenance Organization (HMO) speak about a "Lock-in" provision. What does "Lock-in" mean?*

A The lock-in provision means that you are "locked-in" to receiving care from the HMO's providers. Neither the HMO nor Medicare will pay for services from providers who are not part of the HMO's health care

system. This is true for all services except emergency services which you may receive anywhere, urgently needed care which you may receive while you are temporarily away from the HMO's service area and services to which you may be referred by the HMO. The written information that you receive from the HMO will include the names and addresses of the HMO providers. If you join an HMO with a lock-in provision, in addition to the HMO's written information, you will receive a letter from the Medicare program that tells you about lock-in. This letter from

Medicare will confirm that you are "officially" enrolled in the HMO. It is important to remember that this letter may not bemailed to you until a month or two after you have signed the application to join the HMO.

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Q *Does the lock-in provision apply to all services received by Medicare Health Maintenance Organization (HMO) members?*

A No. While a Medicare member is ordinarily locked-in to certain HMOs for services, a Medicare member is not locked-in for a service that is of an emergency nature no matter where it occurs. The emergency care must be needed immediately because of an injury or sudden illness, and the time required to reach the organization's providers or suppliers would mean risk of permanent damage to your health. You are also not locked-in for urgently-needed services which you need in order to prevent serious deterioration of your health because of an unforeseen illness or injury, provided that the service cannot be delayed until you return to the HMO's service area.

You are also not locked-in to the HMO network if the HMO does not have a lock-in provision. The HMOs which have Medicare contracts and do not have the lock-in provision are more likely to charge coinsurance and deductibles if you receive services from a non-HMO provider.

Further, if the HMO refers you to a non-HMO provider, that service will be considered a covered service since it has been authorized by the HMO. These are the only situations in which the lock-in provision does not apply.

If you do not follow the "lock-in" rules, neither the HMO nor Medicare will pay for the outside services.

EMERGENCY CARE

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Q *I know that most Health Maintenance Organizations (HMOs) require you to obtain services from their health care providers. What happens if I have an emergency? What happens when I am traveling?*

A If you require emergency care anywhere or at any time, or if you are traveling out of the HMO service area and require urgently-needed medical care, the HMO will pay the provider for services furnished to you as long as the condition was an emergency or, in the case of out-of-area urgently-needed care, as long as the condition was unforeseen and treatment could not be delayed until you returned to the HMO's service area. In some cases you may be required to pay the provider of services and then file a claim with the HMO for payment.

The Medicare program will send you a letter which explains the lock-in provision if you have joined an HMO which requires you to receive all of your services from the HMO's health care providers. The HMO can also tell you if the lock-in provision applies to you.

NOTE: Some HMOs may have arrangements to cover emergency services when you are out of the country. Contact the HMO if you think you may require care outside of the U.S.

TRAVELING

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Q *Should I join a Health Maintenance Organization (HMO) if I travel frequently?*

A That is a decision that only you can make. However, there are some things which you should think about when you make that decision. For example, an HMO member who is temporarily away from the HMO's service area is not entitled to coverage of any care other than emergency or urgently-needed services. If you travel frequently you should keep this in mind when deciding whether or not to join an HMO that requires you to use only the HMO providers. Some HMOs with Medicare contracts have affiliate arrangements with HMOs in other areas whereby a traveling HMO member can obtain services at another HMO. Information about such arrangements should be obtained from the HMO.

MOVING AWAY

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Q *What happens if I move away or am absent from the Health Maintenance Organization's service area?*

A If you decide to move permanently from the service area or you plan to be away from the HMO's service area for more than 90 days at a time, you must notify the HMO. Generally, you will be disenrolled from the plan if you have moved permanently or the absence lasts longer than 90 days. Otherwise, you must continue to receive services from the HMO (except for urgently needed care out of the area or emergency care anywhere).

HMOs are permitted to retain members who are absent from the HMO's service area by agreement between the HMO and the member, provided that the member does not intend to make a permanent move. Some restrictions may apply to this provision. If you are a member of an HMO or, if you are thinking about joining an HMO, you need to contact the HMO to see if this option is available to you and what restrictions apply.

HELP FROM SSA

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Q *I am not sure if I am enrolled in a Health Maintenance Organization (HMO): can someone from a Social Security office tell me if I am enrolled?*

A Yes. The Social Security Administration (SSA) can tell you if you are enrolled in an HMO by reviewing the records which they maintain. If your bills for Medicare services are not being paid because you recently joined an HMO or changed from one HMO to another, the SSA office can verify your HMO status to help you straighten out any problems.

CORRECTING RECORDS

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Q *I am enrolled in a Health Maintenance Organization (HMO) with a Medicare contract. I believe my enrollment records are wrong. Who is responsible for making the correction?*

A You should contact your HMO if you believe your enrollment records are wrong. HMOs are responsible for notifying the Health Care Financing Administration (HCFA) of enrollment problems. When appropriate, HCFA will correct the record and a notice of change will be sent to Medicare contractors. This is done so that Medicare will know whether to pay the HMO or non HMO providers for medical claims. Future claims can then be processed correctly as either HMO or Medicare fee-for-service claims. You can also get help through your local Social Security office if your enrollment record is not correct.

DISENROLLING
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Q *How does a person disenroll from a Health Maintenance Organization (HMO)?*

A As a Medicare beneficiary enrolled in an HMO, you may voluntarily disenroll from the HMO for any reason. Just submit a signed and dated request for disenrollment to the HMO or to a Social Security office.

The written disenrollment request may be mailed to the HMO. You do not have to go to the HMO office to disenroll. You can also disenroll at any local Social Security Office. Your disenrollment will be effective the first day of the month after your signed disenrollment request is received by either the HMO or the Social Security Office.

If you are a member of one HMO with a Medicare contract and decide to join a different HMO that has a Medicare contract, you will automatically be disenrolled from the first HMO without having to submit a written request. Be sure to discuss your disenrollment with your new HMO.

INVOLUNTARY DISENROLLMENT
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Q *Can I be disenrolled from a Medicare Health Maintenance Organization (HMO) without my permission?*

A Yes. As a Medicare beneficiary enrolled in an HMO, you may be disenrolled by the HMO under the following conditions:

- you decide to stop your Medicare Part B coverage.
- you fail to pay the HMO premiums or approved copayments and the HMO has given you a reasonable chance to make the payments.
- you permanently move outside of the HMO's service area, or you leave the HMO's geographic area for an extended absence of more than 90 days.
- you commit fraud or permit abuse of the HMO membership card.
- your behavior is disruptive, unruly, abusive, or uncooperative to the extent that your continuing membership in the HMO seriously impairs the HMO's ability to furnish services to either you or other members. The Health Care Financing Administration must first approve the HMO's disenrollment for this reason.

- either your HMO or the Health Care Financing Administration cancels the HMO's Medicare contract. If this occurs, you will be given the opportunity to enroll in another HMO (if one is in the area) or return to traditional fee-for-service Medicare.

The HMO must attempt to contact you under any of these conditions and then provide a written notice regarding the disenrollment action. The notice will provide an opportunity for you to respond before disenrollment occurs.

EFFECTIVE DATE

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Q *When is disenrollment from a Medicare Health Maintenance Organization (HMO) effective?*

A If you decide to disenroll from a Medicare HMO, the termination will be effective as of the first day of the month following the month that the HMO or SSA received the written request for disenrollment (unless a later date is requested). You may ask that your disenrollment be effective as late as three months after you send in your request (i.e., you may send in your request at the beginning of June for an effective disenrollment date of July 1, August 1 or September 1).

If you are a member of one Medicare HMO and decide to enroll in another Medicare HMO, you will be automatically disenrolled from your old HMO when you join the new HMO. If you decide to rejoin your first HMO, you must complete a new application.

Disenrollment by the HMO without your permission is not effective until after you have been notified. Remember, you will automatically be disenrolled if you lose or drop your Medicare Part B coverage.

MEMBERSHIP COST

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Q *What will membership in a Health Maintenance Organization (HMO) cost a Medicare beneficiary?*

A The total cost of HMO membership will vary by HMO. Depending on the HMO, you may have to pay a premium to the HMO, copayments or coinsurance for certain services, or a deductible. HMOs may also offer two or more coverage options, one or more with expanded coverage at a higher premium.

For Medicare covered services, an HMO is prohibited by law from charging a Medicare beneficiary more than an amount specified by

Medicare. Each year HCFA informs the HMO of this maximum amount and the HMO must inform its Medicare enrollees.

Remember that, separate from your payment to the HMO, you are always responsible for payment of your Medicare Part B premium. If you receive a monthly Social Security check, this is the premium that is withheld from your check.

COST TO GOVERNMENT

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Q *I understand that the Government is paying the health maintenance organization (HMO) on my behalf. If so, how much is being paid?*

A The payment made by the Government for each enrolled Medicare beneficiary will vary by HMO. The payment is based in part on how much it would cost the Medicare program if the Medicare beneficiary received services under the traditional fee-for-service program and the location of the HMO.

MEDIGAP

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Q *I have a Medigap policy. What should I do with it if I decide to join a Health Maintenance Organization (HMO) with a Medicare contract?*

A You will not need a Medigap policy if you join an HMO under a Medicare contract. The HMO will offer Medicare supplemental benefits, such as coverage of deductibles or coinsurance, as part of its overall Medicare benefits. Most HMOs will charge a premium for these supplemental services. Often this premium is less than you would pay for a Medigap policy. In many cases, the HMO will also include additional benefits that are not available through a standard Medigap policy.

If you already have a Medigap policy to supplement your fee-for-service Medicare coverage and you decide to join an HMO, you may keep your Medigap policy for 30 days while you see if you like the HMO.

HMO REFUSES TO PAY

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Q *What should I do if a Health Maintenance Organization (HMO) refuses to provide or pay for a service?*

A If the HMO refuses to pay for any service, or refuses to provide a Medicare covered service, and you believe it should pay for or provide the service,

you may make a written appeal to the HMO. Federal regulations require HMOs to follow special appeals requirements in the following situations:

- the HMO has refused to provide a Medicare covered service, or
- you received a service covered by Medicare, and you or the provider billed the HMO for the service and the HMO has refused to pay.

The information provided to you when you join an HMO will explain your appeal rights, which include the right to a review by the Health Care Financing Administration.

COMPLAINTS 20

Q *What happens if I have a complaint about my Health Maintenance Organization (HMO) that is not related to payments?*

A If you have a complaint about the quality of care received from an HMO with a Medicare contract, you can follow your HMO grievance procedure or complain to the Medicare Peer Review Organization in your area. These organizations are made up of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients.

If the complaint is about deceptive or misleading advertising, questionable enrollment or marketing practices, long waiting periods for appointments, and related matters, you should file your complaint with the HMO. You may also write to the nearest Health Care Financing Administration regional office.

MEDICARE CARD 21

Q *Won't I have to give up my Medicare card if I join a health maintenance organization (HMO)?*

A No. You will not have to give up your Medicare card.

In some instances, the HMO will place a "sticker" on your Medicare card to identify you as an HMO enrollee. Most HMOs will give you a separate membership card to identify you as a member. You must use the HMO membership card when you receive health care services. If you use your

Medicare card to receive health care services after you have joined an HMO with a Medicare contract, Medicare will not pay for your care.

NOTE: You are still a Medicare beneficiary if you join an HMO with a Medicare contract. As a Medicare enrollee, Medicare is making a monthly payment to the HMO to help pay for health care you receive from HMO providers. The HMO health care option is available for most Medicare beneficiaries and each Medicare beneficiary is encouraged to explore the advantages of this option to determine if HMO enrollment is a better way to receive Medicare covered services.

HMO TYPES

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Q *Is there more than one type of Health Maintenance Organization (HMO) model?*

A Yes. There are two basic types of HMOs, the staff or medical group model and the individual practice model.

Staff and group model HMOs generally provide services from central locations where many doctors, laboratories and other services are located in one place. Individual practice model HMOs are made up of doctors located in their own offices throughout the community.

Each of these models has strong points. Staff and group model HMOs may be more convenient for you since they provide most services at the same location. Individual practice HMOs may have more doctors to choose from. If your current doctor is a member of either of these models, you will generally still be able to see him or her after you join the HMO.

SAME HMO AS SPOUSE

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Q *My husband and I have medical coverage under two different health care plans. Both of us are eligible for Medicare and I want to know if we should join the same health care plan? He is retired but I am still working on a part-time basis.*

A The choice is yours. You do not have to belong to the same health care plan unless you want to. One of you can belong to a Health Maintenance Organization (HMO) and the other can receive health care under the Medicare fee-for-service program. Each of you can also belong to different HMOs.

Since you indicate that you already belong to different health care plans, it would be a good idea for you to review the coverage provided under each of the plans and the cost to you. In this way, you can make sure you are both getting the best health care package at a price that you can afford.

If you have trouble understanding the health care benefits provided by each of the plans, you may be able to obtain help from some senior centers and other retiree organizations. Your employer's personnel office may also be able to assist you in understanding your health care benefit options.

SELECTING A DOCTOR

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Q *I have heard that you don't get your own doctor under Health Maintenance Organizations (HMOs). Is that true?*

A No. When you first join an HMO, you are asked to select a primary care physician from a panel of physicians. That physician serves as your personal doctor and is responsible for referring you to other specialists. If for any reason you are not satisfied with the doctor, you may request a different primary care physician and another doctor will be assigned to you. It is very important that you and the doctor achieve a comfortable relationship. As a first step, you may want to talk to your current doctor to see if he or she belongs to an HMO. Then you can contact the HMO to see if the HMO has a Medicare contract to provide health care services to Medicare beneficiaries.

ADDITIONAL COVERAGE

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Q *I have heard that Health Maintenance Organizations (HMOs) provide preventive health care including check-ups as appropriate for your age and health status. Is that true?*

A Yes. Most HMOs provide routine physicals as part of a larger program of preventive medicine. Usually the preventive care approach includes such non-Medicare covered services as immunizations and health education. Most HMOs also provide additional services which are not covered by Medicare such as eye, ear and dental care. Some of these services may be provided at no additional cost to you. In other cases, these services may be available for a nominal fee. You can ask the HMO what services are provided that are in addition to the basic Medicare covered benefits and if these services will cost you an additional fee.

ADVANTAGES

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Q *What are the advantages of joining a health maintenance organization (HMO) over fee-for-service? What is in it for me?*

A There are several advantages to joining an HMO over fee-for-service. Some of these advantages include:

- **more benefits:** HMOs offer additional benefits at very little or no additional cost. Most of these additional benefits are not available under Medicare's traditional fee-for-service program.

- **predictable payments:** HMO premium amounts are more predictable and out-of-pocket payments are kept to a minimum. This feature often makes budgeting easier and helps the enrollee to exercise more control over health care costs.

- **convenience:** in many instances, the HMO's health care providers are located in the same area.

- **preventive care:** the HMO package of preventive services will help you stay healthy longer and often detect medical conditions before they become major health care problems.

- **educational services:** HMOs often provide ongoing health education and health related information to encourage healthier and happier lifestyles for Medicare enrollees.

- **quality:** HMOs with Medicare contracts must meet specific requirements and maintain certain standards as a condition for continued participation in the Medicare program.

- **value:** your primary care physician monitors health care received from other providers to reduce instances of inappropriate care and may prevent adverse prescription drug interactions.

- **choice:** if you and your primary care physician are not able to develop a comfortable relationship, you can request that a different doctor be assigned to you.

- **flexibility:** if you are a Medicare beneficiary enrolled in an HMO and you decide HMO enrollment no longer meets your needs, you can return to Medicare's traditional fee-for-service program at any time.

- **access:** HMOs usually provide access to enrollees, by telephone, on a 24-hour basis.

Q Where can I get more information about Health Maintenance Organizations (HMOs) in this area?

A You can contact your nearest State Health Insurance Information, Counseling and Assistance Program, the Health Care Financing Administration Regional Office, and call or write to:

The Resource Library
HCFA Room 4360 Cohen Building
330 Independence Ave., S.W.
Washington, D.C. 20201-0001
(202) 619-0066